Name:

Florida Department of Health, AIDS Drug Assistance Program (ADAP)

Statement of Agreement and Acknowledgement

Authorization to Release

Individuals wanting to enroll in and receive ADAP services are required to provide a written signature or check the box on the form acceptance page that states “I attest that I have read and agree to the terms and conditions stated in the Statement of Agreement and Acknowledgement, as indicated by my submission of an online form.” and click on the “I Accept” button. This allows ADAP to release the applicant’s information to the entities listed on the form for the purposes of coordination of care, treatment, and payment of services.

By providing a written signature or checking the box on the form acceptance page that states “I attest that I have read and agree to the terms and conditions stated in the Statement of Agreement and Acknowledgement, as indicated by my submission of an online form.” and clicking on the “I Accept” button, you certify that you fully understand and agree to abide by the policies stated herein. All references to "program" or "programs" refer to the Florida Department of Health AIDS Drug Assistance Program and/or successor programs in which you participate or to which you apply for services.

Please read the following:

1. I certify that the information provided is true and accurate to the best of my knowledge. I understand that I may be disqualified from this program(s) and/or prosecuted for willfully providing false information.

2. I understand that the information requested is for the purpose of determining whether I qualify for enrollment in the program. The funding is limited and may expire at any time without alternate funds being available, and the Department of Health is not obligated to continue to supply services (medications, insurance premiums, copays or deductibles, other related benefits) indefinitely. Services through this program are supplied as a benefit and not as a right or entitlement.

3. If I am considered eligible for services, my information will be provided to contractual partners for the reasons explained in this document. I authorize the program to release my enrollment, eligibility and service records and other information necessary to facilitate the provision of program services to my physicians, other providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, pharmacies, insurance carriers and insurance benefits coordinators, or any entity under contract with the program.

4. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of 6 months from the date of acceptance, or until such time as I inform the Program in writing, of my wish to terminate services in the Program(s), except to the extent that action has been taken in reliance on this authorization.

5. I acknowledge that my health insurance premiums (if applicable) are being paid by the program via a contractual third-party payer. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the Florida Department of Health’s contracted insurance benefits manager (IBM) entity, Broward Regional Health Planning Council, or any entity under contract with the Florida Department of Health in connection with program services for any

unused premium payments should my insurance policy terminate or be cancelled for any reason, including but not limited to future disenrollment, death, voluntary termination, involuntary cancellation, or termination by operation of law.

6. I agree to indemnify and hold the Florida Department of Health harmless from any and all claims for making premium reimbursement payments directly to Florida Department of Health's contracted insurance benefits manager (IBM) entity, Broward Regional Health Planning Council, or any entity under contract with the Florida Department of Health in connection with program services. I agree to indemnify and hold the Florida Department of Health, or any entity under contract with the Florida Department of Health in connection with program services, harmless from any and all claims for receiving premium reimbursement payments directly from the Florida Department of Health or my health insurer. This agreement shall be binding on my administrators, executors, heirs, successors, and assigns and shall remain in full force and effect during the time period in which I am enrolled in the program(s).

7. I agree to reimburse the Florida Department of Health for any and all premium reimbursement payments that are paid to me in error at any time.

8. I understand that medications dispensed through this program are provided for personal use and that it is illegal to sell, trade, barter, or in any other way exchange these medications with any other person. Such activity is grounds for criminal prosecution.

9. I understand that taking my HIV medicine as directed by my health care provider provides the best chance for the medicine to keep me healthy for the rest of my life.

10. I understand that I cannot stop taking Abacavir, Epzicom, Trizivir, Ziagen, or Triumeq without my doctor's approval. If I stop taking any of these drugs, even for one day, and then start again, I risk having a very bad allergic reaction that can cause serious injury or even death.

11. I understand that it is important to pick up my HIV medication from the county health department, a retail pharmacy, or my medical provider before I run out of medicine. Failing to pick up my medications on time may affect my ability to remain enrolled in the program.

12. I understand the importance of not stopping my medications. If I am late picking up my medications, ADAP staff may contact my health care provider to get approval to begin receiving medications again.

13. I understand that missing scheduled medication doses could result in my virus becoming resistant to one or more of my HIV medications, meaning that HIV medication will no longer work in keeping my virus controlled.

14. I understand that if I regularly have problems picking up my medications on time or taking them as I have been told to, I may have to meet with my health care provider and ADAP staff about my treatment.

15. I agree to tell my health care provider and pharmacist about all my medications, including over-the-counter medicines, vitamins, and herbal and dietary supplement, since there can be interactions with my HIV medications. Before starting a new medication, I should talk to my health care provider or pharmacist to make sure it is safe to take the new medication with my HIV medicine.

16. I understand that if I am confused or need help with my medications, I should contact my health care provider. If I am confused about when I need to pick up my medications, I should contact

ADAP staff at the Florida Department of Health in the county I receive services or, if I receive my medications from the CVS Specialty Pharmacy, I should call CVS Specialty Pharmacy at 1-800-498-2037.

17. I understand that medications provided through the program may have dangerous side effects and that my physician should explain to me all possible side effects.

18. I agree that should I become eligible for treatment under a different program, I will notify the local ADAP manager or pharmacist so that I may continue to receive treatment under a different source of payment.

19. I understand that it is important to take my HIV medications with me if I travel. Should I lose my medications while I am out of town, ADAP may not be able to assist.

20. I understand that my personal health information may be included within any documents I choose to upload, including the HIV lab results (CD4 T-Cell count and HIV viral load) that are required by the program at least every 6 months. I understand program staff may request my lab information from my provider or through the state's electronic lab reporting system.

21. I agree to treat ADAP staff with courtesy and consideration.

The agencies listed below, and their subcontractors, work with the Florida Department of Health to coordinate and verify eligibility for all services adhering to the same expectations identified above in statements 1-19:

- A.H. of Monroe County, Inc.
- Basic NWFL, Inc.
- Big Bend Cares, Inc.
- Broward Regional Health Planning Council, Inc.
- Centers for Medicare & Medicaid Services
- CVS Caremark L.L.C. (CVS Health)
- Florida Department of Children and Families
- Groupware Technologies, Inc.
- Heart of Florida United Way, Inc.
- OASIS, Inc.
- South Florida AIDS Network
- WellFlorida Council, Inc.

If you receive program services within one of the state's emerging metropolitan areas or transitional grant areas, your records will be accessible by the Ryan White Part A designated agency.

If you receive services from a Ryan White Part B provider, your ADAP information will be accessible by the Ryan White Part B provider through state's CAREWare system.

Client Attestation: I attest that I have read and agree to the terms and conditions stated in the Statement of Agreement and Acknowledgement, as indicated by my submission of an online form or by my written signature.

Date Attested Online:

Client/Applicant Last Name, Client/Applicant First Name

Or

Client Signature Date

ADAP Staff Signature Date